

038058

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05378

1- STATE REGISTRAR

DECEASED NAME (TYPE OR PRINT) DR. <u>BARRY</u>			FIRST <u>ARONSON</u>			MIDDLE <u>ARONSON</u>			LAST <u>ARONSON</u>			2a. DATE KNOWN OF DEATH ESTIMATED MONTH <u>2</u> DAY <u>1</u> YEAR <u>1986</u>			7b. HOUR <u>1803</u>				
3. SEX <u>MALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH <u>7</u> DAY <u>15</u> YEAR <u>45</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>40</u> YRS.		IF UNDER 1 YR. MONTHS <u>0</u> DAYS <u>0</u>		IF UNDER 24 HRS. HOURS <u>0</u> MIN <u>0</u>		2c. DATE PRONOUNCED DEAD MONTH <u>2</u> DAY <u>1</u> YEAR <u>1986</u>			7d. HOUR <u>1803</u>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>NEW YORK</u>				7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <u>HOWARD</u> COUNTY MD.							
10. CITY OR TOWN OF DEATH <u>COLUMBIA</u>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOWARD COUNTY GENERAL HOSPITAL</u>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>ORTHOPEDIC SURGEON</u>				12b. KIND OF BUSINESS OR INDUSTRY <u>MEDICINE</u>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u> 13b. COUNTY <u>HOWARD</u> 13c. CITY OR TOWN <u>DAYTON</u>								13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS (21036) <u>13520 ORION DRIVE</u>									
14. FATHER'S NAME FIRST <u>HAROLD</u> MIDDLE <u>ARONSON</u> LAST <u>ARONSON</u>						15. MOTHER'S MAIDEN NAME FIRST <u>SELMA</u> MIDDLE <u>LERNER</u> LAST <u>LERNER</u>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>NO</u>				16b. SOCIAL SECURITY NO. <u>125-36-2276</u>				17. INFORMANT ADDRESS <u>DAYTON MD 21036</u> <u>MRS. BARBARA ARONSON 13520 ORION DR.</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <u>Thomas F. Herbert</u>				TITLE (SPECIFY) <u>Deputy</u> MEDICAL EXAMINER				DATE SIGNED <u>2-1-86</u>											
EXAMINER'S NAME (TYPE OR PRINT) <u>Thomas F. Herbert, MD</u>				ADDRESS <u>Ellicott City MD 21043</u>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				23b. DATE <u>2/3/86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HAR SINAI CEM</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>OWINGS MILLS BALTO MD</u>									
24. FUNERAL DIRECTOR NAME <u>SOL LEVINSON &amp; BROS., INC.</u>								25a. DATE REC'D. BY REGISTRAR <u>FEB 05 1986</u>				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							
6010 REISTERSTOWN RD., BALTIMORE, MD 21215																			

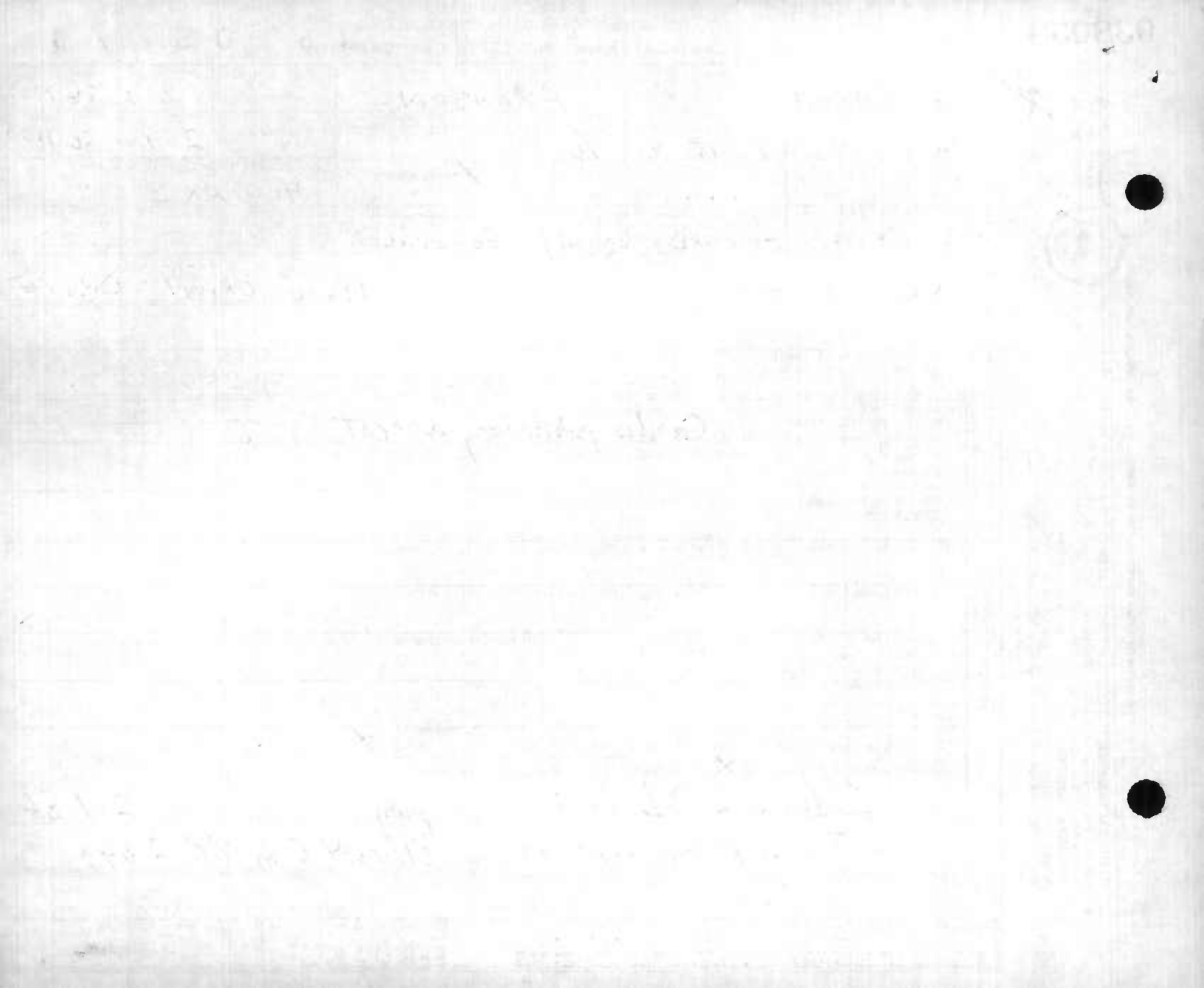
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2, WHEN COMPLETED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))



052112

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL UNDER ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05379

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST LORING		MIDDLE RILEY		LAST BOYCE		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 2		DAY 9		YEAR 1986		2b. HOUR 9:52			
3. SEX MALE		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 3-18-05		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 2-9 1986		7d. HOUR 9:52			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard Co. MD.													
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9660 Barrel House Road Apt G						17a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter				17b. KIND OF BUSINESS OR INDUSTRY Construction							
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 20707 9660 Barrel House Road Apt G											
14. FATHER'S NAME FIRST MIDDLE LAST Carl Boyce				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Virginia Tevalt															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 01 7660 A				17. INFORMANT ADDRESS Eleanor Boyce same as above											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Thomas F. Herbert				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 2-9-86							
EXAMINER'S NAME (TYPE OR PRINT) Thomas F. Herbert, MD				ADDRESS Ellicott City, MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation				23b. DATE 2-13-1986				23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville MD							
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home P.A. Laurel, MD								25a. DATE REC'D. BY REGISTRAR FEB 18 1986								25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



049068

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 3 8 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Melville</u> <u>Bush</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>2/7/86</u>		2b. HOUR <u>2:40</u> <u>A</u> <u>M</u>	
3. SEX <u>Male</u>	4. RACE <u>W</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>April 21, 1902</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>83</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Vancouver Washington</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Howard</u> MD.		
10. CITY OR TOWN OF DEATH <u>Columbia</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Howard Co General</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md</u>			13b. COUNTY <u>Howard</u>	13c. CITY OR TOWN <u>Columbia</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>11056 Swansfield Rd, Columbia Md</u> <u>21044</u>
14. FATHER'S NAME FIRST MIDDLE LAST <u>Edgar</u> <u>Bush</u> <u>Mabel</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Davis</u>			

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>	(IF YES, GIVE WAR OR DATES) <u>WWII</u>	16b. SOCIAL SECURITY NO. <u>543-46-7261</u>	17. INFORMANT <u>Roderick D Bush</u>	ADDRESS <u>11056 Swansfield Rd, Columbia Md</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Acute Renal failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>1:22</u> <u>P.M.</u> <u>19</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
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22a. I certify that (I) (this hospital) attended the deceased from <u>1-22</u> , 19 <u>86</u> , to <u>2-6</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>2-6</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
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22b. SIGNATURE <u>Krishna P. Kumar</u>	DEGREE	22c. DATE SIGNED <u>2-7-86</u>
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KRISHNA P. KUMAR</u>	22e. ADDRESS <u>10802 HICKORY RIDGERD COLUMBIA</u> <u>21044</u>
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>2-10-86</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Md Veterans Crownsville Crownsville Anne Arundel Md</u>	23d. LOCATION CITY OR TOWN COUNTY STATE
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24. FUNERAL DIRECTOR NAME <u>Harry H Witzke</u>	ADDRESS <u>4112 Columbia Rd, Ellicott City Md</u>	25a. DATE REC'D. BY REGISTRAR <u>FEB 13 1986</u>	25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in its entirety, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must have post-mortem at once.



063014

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the undersigned. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 6 0 5 3 8 1	
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1 DECEASED NAME				REG. NO.	
1a DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH	
NELSON CAMPBELL				2 25 86 420A <sup>PM</sup>	
3 SEX		4 RACE		5 DATE OF BIRTH	
MALE		CAUC.		12 20 93	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		6 AGE (IN YEARS LAST BIRTHDAY)	
New Jersey		U.S.A.		92	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		9 BALTIMORE CITY OR COUNTY OF DEATH	
Columbia		Howard County General Hospital		HOWARD MD.	
12a USUAL OCCUPATION (TYPE OR PLURAL FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Retired		Electrician			
13a STATE 13b COUNTY 13c CITY OR TOWN 13d INSIDE CITY LIMITS? 13e STREET ADDRESS / ZIP CODE					
Maryland Howard Columbia YES NO 5404 Harvest Moon Lane 21044					
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
Unknown			Unknown		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
Yes		WW 1 142 30 5030A		M's Viola Campbell 5404 Harvest Moon Lane	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) CEREBELLAR HEMORRHAGE					
DUE TO, OR AS A CONSEQUENCE OF (b) UNKNOWN					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HISTORY OF CEREBROVASCULAR DISEASE					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	
				YES NO	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 2/23/86, 19 86, to 2/25, 19 86, that (I) (we) lost saw the deceased alive on 2/24, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE				22c DATE SIGNED	
Scott Maurer MD					
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS	
MAURER				11085 LITTLE PAT. PKWY COLUMBIA	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Cremation		Feb 26 '86		Westview Memorial Park	
24 FUNERAL DIRECTOR NAME		24b ADDRESS		23d LOCATION CITY OR TOWN COUNTY STATE	
Harry H Witzke & Family Funeral Home		Inc 4112 Old Columbia Pike Ellicott City		Catonsville, Balto., Maryland	
25a DATE RECD BY REGISTRAR 25b REGISTRAR SIGNATURE					
FEB 28 1986					

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CHIEF

CHIEF

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049067

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

0 5 3 8 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Arthur B Caven</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2/4/86</b>		2b. HOUR <b>7:07 PM</b>					
1. SEX <b>Male</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 8, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Dakota</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.				
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard Co General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md</b>			13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott City</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1901 St Johns Lane Ellicott City 21043</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT ADDRESS <b>Ellicott City Md</b> <b>Katherine Caven, 3901 St Johns Lane</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION <b>2/1/86</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PRE-AMPUTATION, RT FOOT</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>1/27</b> 19 <b>86</b> , to <b>2/4</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>2/4/86</b> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Reve L. Gelber MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/4/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>REVE L. GELBER</b>			22e. ADDRESS <b>10808 HICKORY RIDGE RD COLUMBIA MD 21044</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>2-6-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto Md</b>			
24. FUNERAL DIRECTOR NAME <b>Harry H Witzke</b>			ADDRESS <b>4112 Columbia Rd, Ellicott City Md</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 13 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>		

03902

NAME	DATE	TIME	LOCATION
Howard to Howard	1912	7:30	Howard
Howard to Howard	1912	7:30	Howard
Howard to Howard	1912	7:30	Howard

Howard to Howard  
Howard to Howard  
Howard to Howard

Howard to Howard  
Howard to Howard  
Howard to Howard

050098

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

0 5 3 8 3

FOR  
STATE  
REGISTRAR MARGARET E. CHOYAN

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Margaret E. Chohan</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>2 13 86</i>			2b. HOUR <i>940</i> M				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>October 2, 1901</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard County</i> MD.				
10. CITY OR TOWN OF DEATH <i>Columbia</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Howard County General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Cleaning</i>		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Howard</i>		13c. CITY OR TOWN <i>Ellicott City</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>8760 C Town &amp; Country Blvd 21043</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Jefferson Shields</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Julia Whalen</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>381-03-0567</i>		17. INFORMANT ADDRESS <i>Mr. Albert Shields 401 North Bend Road Baltimore, MD. 21229</i>					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary artery heart</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Seconds</i>		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Constrictive heart failure</i>								<i>Years</i>		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary artery disease</i>								<i>Years</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>[Signature]</i>			DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <i>2-13-86</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Derek I. Lewis MD</i>			22e. ADDRESS <i>Columbia, Ind 21044</i>							
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>			23b. DATE <i>2/18/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Garrison Forest Veterans</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Orwings Mills Maryland</i>			
24. BY: <i>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</i> 1630 Edmondson Avenue, Catonsville, MD. 21228					25a. DATE REC'D BY REGISTRAR <i>FEB 14 1986</i>					



056025

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for further investigation.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>LUCY</b>		FIRST <b>LUCY</b> MIDDLE <b>COLEMAN</b> LAST <b>COLEMAN</b>		2a. DATE OF DEATH MONTH <b>2</b> DAY <b>20</b> YEAR <b>86</b> HOUR <b>6:55</b> AM		REG. NO. <b>05384</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>01</b> DAY <b>13</b> YEAR <b>01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS		IF UNDER 1 YEAR MONTHS <b>02</b> DAYS <b>20</b> IF UNDER 24 HRS. HOURS <b>6</b> MIN. <b>55</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b> COUNTY <b>Baltimore</b> CITY OR TOWN <b>Catonsville</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>106 Park Drive 21228</b>			
14. FATHER'S NAME FIRST <b>Ernest</b> MIDDLE <b>White</b> LAST <b>White</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Susan</b> MIDDLE <b>Albaugh</b> LAST <b>Albaugh</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-56-2465</b>		17. INFORMANT <b>Carol Carter</b> ADDRESS <b>3638 Cragmoore Court Ellicott City, MD, 21043</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b>									
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRON'S DISEASE</b>									
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRON'S DISEASE</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b>A.M.</b> MONTH <b>01</b> DAY <b>30</b> YEAR <b>86</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>106 Park Drive</b> CITY OR TOWN <b>Columbia</b> COUNTY <b>Howard</b> STATE <b>Maryland</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>01/30</b> 19 <b>86</b> , to <b>02/20</b> 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>02/20</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Kaushalendra K. Singh, M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/20/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KAUSHALENDRA K. SINGH</b>		22e. ADDRESS <b>HOWARD COUNTY HOSPITAL Columbia, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>2/22/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Ellicott City</b> COUNTY <b>Howard</b> STATE <b>Maryland</b>			
24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke</b>				25a. DATE REC'D BY REGISTRAR <b>FEB 21 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Jane Anderson</b>			

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WINDY

057098

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 3 8 5

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RALPH A. COONEY			2a DATE OF DEATH MONTH DAY YEAR 2 21 86		2b HOUR 10:05 P.M.
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR 9 27 18		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.	
10 CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Purchasing Agent		12b KIND OF BUSINESS OR INDUSTRY Westinghouse
13a STATE Maryland			13b COUNTY Howard	13c CITY OR TOWN Columbia	
14 FATHER'S NAME FIRST MIDDLE LAST William H. Cooney, Sr.			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne M. Feeney		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 216-18-9275		17 INFORMANT ADDRESS James C. Meyer 8621 S. Bali Ct. 21043	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ischemic cardiomyopathy</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes minutes years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <u>Ventricular tachycardia ventricular fibrillation renal failure</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 2/16 19 86 to 2/21 19 86, that (I) (we) last saw the deceased alive on 2/21 19 86, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Stephen A. Valentini		DEGREE		22c DATE SIGNED 2/21/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) VALENTI, STEPHEN A		22e ADDRESS Howard County General Hospital			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 2/25/86		23c NAME OF CEMETERY OR CREMATORY St. Augustins Cem.	
23d LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Md.		23e DATE RECEIVED BY REGISTRAR 25b REGISTRAR'S SIGNATURE FEB 24 1986			
24 FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 21229 4107 Wilkens Ave.		25a DATE RECEIVED BY REGISTRAR 25b REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP







050107

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 0 5 3 8 6

1. DECEASED NAME (TYPE OR PRINT) <b>ELLA</b>		FIRST <b>A.</b>		MIDDLE <b>DURBIN</b>		LAST <b>DURBIN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>2/13/86</b>		2b. HOUR <b>549</b> A M	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7/8/06</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.					
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Woodbine</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>15755 Union Chapel Rd. 21797</b>			
14 FATHER'S NAME FIRST <b>Otto</b> MIDDLE <b></b> LAST <b>Mantzke</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Bertha</b> MIDDLE <b></b> LAST <b>Goltz</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. <b>577-07-2841B</b>		17 INFORMANT ADDRESS <b>William E. Durbin-husband-(same as 13e)</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA with seizure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SEPSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>2/10/86</b> 19____, to <b>2/13/86</b> 19____, that (I) (we) last saw the deceased alive on <b>2/13/86</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>Gebreye Rufaul</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>2/13/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gebreye Rufaul</b>				22e. ADDRESS <b>10840 LITTLE PATUXENT PKY STE 302, Columbia, Md. 21044</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-17-1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Montgomery Md.</b>					
24 FUNERAL DIRECTOR <b>Hines/Rinaldi Funeral Home</b>				11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR <b>FEB 14 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 3 8 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Aimee G. Eagleston		2a. DATE OF DEATH MONTH DAY YEAR February 17, 1986		2b. HOUR 12:30 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01 22 87	
6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE, GIVE STREET ADDRESS) Howard County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hat Maker	
12b. KIND OF BUSINESS OR INDUSTRY M.S. Levy					

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY --		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST George E. Eagleston		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marian Carr		16. STREET ADDRESS / ZIP CODE 6000 Park Heights Avenue 21215	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		17b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-05-9018		17. INFORMANT Edward S. Kallins ADDRESS 6611 Greenspring Ave. Baltimore, MD. 21209	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable myocardial infarction with arrhythmia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF: (b) Atherosclerotic cardiovascular disease more than 10 yrs	
		DUE TO, OR AS A CONSEQUENCE OF: (c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 17 Feb 1986 to 17 Feb 1986, that (I) (we) last saw the deceased alive on 17 Feb 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22a. SIGNATURE Stephen Zemel M.D.		DEGREE		22c. DATE SIGNED 02/17/86	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Zemel M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
		22e. ADDRESS Howard County Gen Hosp - 5755 Cedar Ln Columbia, MD 21044			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/20/86		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	
				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	

24. FUNERAL DIRECTOR (NAME) Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228		25a. DATE REC'D. BY REGISTRAR FEB 21 1986		25b. REGISTRAR'S SIGNATURE June Davidson-Randall	
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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 3 8 8

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARGARET L. FAWCETT</b>			2a DATE OF DEATH MONTH DAY YEAR <b>February 12, 1986</b>		2b HOUR IF UNDER 24 HRS <b>7:50A M</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>October 6, 1910</b>		6 AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <b>75</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.		
10 CITY OR TOWN OF DEATH <b>Ellicott City</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secour Extended Care</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Office Manager</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Trucking Co.</b>		
13a STATE <b>Maryland</b>			13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Catonsville</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Morgan</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gwen Jones</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>187-05-6224A</b>		17 INFORMANT ADDRESS <b>Vania Fawcett Same as # 13</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Chronic Coronary Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Age</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>Chronic obstructive Pulmonary Disease</b>								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <b>9/1/85</b> 19 <b>85</b> to <b>1/11</b> 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>1/11</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b SIGNATURE <b>Cliff Ratliff Jr.</b>				DEGREE <b>M.D.</b>		22c DATE SIGNED <b>2/12/86</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Cliff Ratliff Jr. M.D.</b>				22e ADDRESS <b>5772 Westview Mall, Baltimore, MD.</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>2/15/86</b>		23c NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial Park</b>		23d LOCATION (CITY OR TOWN) COUNTY STATE <b>Dorsey MD.</b>		
24a NAME OF DIRECTOR <b>Russell C. Witzke</b>				24b ADDRESS <b>1630 Edmondson Avenue, Catonsville, MD. 21228</b>		25a DATE REC'D. BY REGISTRAR <b>FEB 14 1986</b>		
25b REGISTRAR'S SIGNATURE <b>Russell C. Witzke</b>								

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 3 8 9

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HARRIETT E FLEAGLE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 8 86</b>		2b. HOUR <b>6:58</b> P.M.
1. SEX <b>F</b>	4 RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 10 26</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>60</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.		
10 CITY OR TOWN OF DEATH <b>Columbia</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>Columbia</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Sidney S Hayes</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Stranathan</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (ES. NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>293 20 5813</b>		17 INFORMANT ADDRESS <b>Wilbert J Fleagle 9036 Watchlight Court</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asystole + Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>Recent @ Cerebral Anoxia w/ @ Hemiparesis @ and @</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 18</b> 19 <b>86</b> , to <b>Feb 8</b> 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>Feb 8</b> 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>L. A. SWANK</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>2-9-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L. A. SWANK</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>		23b. DATE <b>Feb 12, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crestlawn</b>	
23d. LOCATION CITY OR TOWN <b>Howard</b>		COUNTY <b>Maryland</b>		STATE	
24 FUNERAL DIRECTOR NAME <b>Harry H Witzke &amp; Family Funeral Home</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 13 1986</b>		
ADDRESS <b>Inc 4112 Old Columbia Pike Ellicott City</b>			25b. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked "Not at Work," item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

PERRY LINVILL FRIDLEY

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Perry LINVILL FRIDLEY</b>			2a. DATE OF DEATH <b>2</b> MONTH <b>25</b> DAY <b>86</b> YEAR <b>2/25/86</b>		2b. HOUR <b>0235</b> M
3. SEX <b>MALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>12</b> DAY <b>27</b> YEAR <b>19</b> <b>19</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County MD.</b>	
10. CITY OR TOWN OF DEATH <b>COLUMBIA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard Co General Hsp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>State Penitentiary Guard</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Security</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>Jessup</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX	13e. STREET ADDRESS / ZIP CODE <b>7739 Sharewood Drive 20794</b>	
14. FATHER'S NAME FIRST <b>Ira</b> MIDDLE <b>D.</b> LAST <b>Fridley</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Madge</b> MIDDLE <b>Heckert</b> LAST <b>Heckert</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>	17. INFORMANT ADDRESS <b>Mrs. Ruth V. Fridley Same as # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Exac. COPD</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>ISCHEMIC HEART DISEASE</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>OCT</b> 19 <b>85</b> , to <b>FEB</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>JAN</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Edward W. Schaefer MD</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/25/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD W. SCHAEFER MD</b>		22e. ADDRESS <b>Columbia, MD. HOWARD COUNTY GEN. HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>	23b. DATE <b>2/28/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Phillipi Barbour W. VA.</b>		
24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Gina Davidson-Rendall</b>	
1630 Edmondson Avenue, Catonsville, MD. 21228		<b>MAR 5 1986</b>			

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(VRA 15, 4)

FOR 1 - STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 0 5 3 9 1 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Mrs. Mildred Cecilia Gartside</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>February 19 1986</b>										2b. HOUR <b>12 NOON</b>	
3. SEX <b>Female</b>			4. RACE <b>Caucasian</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>December 16 1904</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>			7. IF UNDER 1 YEAR MONTHS DAYS YRS.			8. IF UNDER 24 HRS. HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.												
10. CITY OR TOWN OF DEATH <b>Ellicott City</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Extended Care Facility</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>										13b. CITY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6130 Wheatland Road 21228</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Neeb</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose D'Antoni</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-46-2058</b>			17. DECEASED'S NAME FIRST MIDDLE LAST <b>Mr. George Henry Gartside Jr.</b>			17a. ADDRESS <b>6130 Wheatland Road Catonsville Maryland 21228</b>												
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last. (b) <b>renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>bladder carcinoma</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a) <b>Dementia</b>																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>11085 LITTLE PRA. PKWY COLUMBIA 21048</b>															
22a. I certify that (I) (this hospital) attended the deceased from <b>12/20</b> 19 <b>85</b> , to <b>1/15</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>1/13</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										22b. SIGNATURE <b>Leann Maurer MD</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22c. DATE SIGNED										22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MAURER</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12-22-86</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore Maryland</b>												
24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133</b>										25a. DATE REC'D. BY REGISTRAR <b>FEB 21 1986</b>			25b. REGISTRAR'S SIGNATURE								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 states any injury, or other traumatic event, the medical examiner must be notified.

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For Security Services, New York City

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 3 9 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Vincent R GARY</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>2 4 86</i>			2b. HOUR <i>6 35</i> M			
3. SEX <i>Male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>03 05 23</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>62</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Columbia</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Howard County Gen. Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Engineer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Fed. Gov't</i>	
13a. STATE <i>Md.</i>			13b. COUNTY <i>Howard</i>		13c. CITY OR TOWN <i>Columbia</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>John C. Gary</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Helen C. Smith</i>			13e. STREET ADDRESS / ZIP CODE <i>5743 Thunder Hill Rd. 21045</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WWII</i>		17. INFORMANT <i>Ms. June T. Barksdale</i>		ADDRESS <i>24 Norton Rd. 08852 Monmouth Junction, NJ</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Adenocarcinoma - metastatic</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Atherosclerotic Heart Disease, Chronic Anemia, Heart Failure</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 1</i> , 19 <i>86</i> , to <i>Feb 4</i> , 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>Feb 4</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Jon Munford</i>					DEGREE <i>MD</i>			22c. DATE SIGNED <i>2-6-86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jon K. Munford</i>					22e. ADDRESS <i>10806 Hickory Ridge Rd, Columbia MD 21044</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>			23b. DATE <i>2/6/86</i>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <i>Anatomy Board</i>					ADDRESS <i>Balto., Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 13 1986</i>		
					25b. REGISTRAR'S SIGNATURE <i>Julia Kristina Randall</i>				

MEDICAL CERTIFICATION

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9

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and place them in the container provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>William A GUYTON</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>2 21 86</i>			2b. HOUR <i>7.30 A.M.</i>			
3. SEX <i>Male</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 01 25</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>80</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard</i> MD.			
10. CITY OR TOWN OF DEATH <i>Columbia</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Howard County General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>machinist</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Md.</i> COUNTY <i>Howard</i> CITY OR TOWN <i>Dorsey</i>		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE <i>7010 Elm Ave 21227</i>		14. FATHER'S NAME FIRST <i>unknown</i> MIDDLE <i>unknown</i> LAST <i>unknown</i>			
15. MOTHER'S MAIDEN NAME FIRST <i>unknown</i> MIDDLE <i>unknown</i> LAST <i>unknown</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>212 09 8544</i>		17. INFORMANT ADDRESS <i>7010 Elm Ave.</i> <i>Michael E. Guyton Dorsey, Md. 21227</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Pneumonia*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) *STROKE*

DUE TO, OR AS A CONSEQUENCE OF

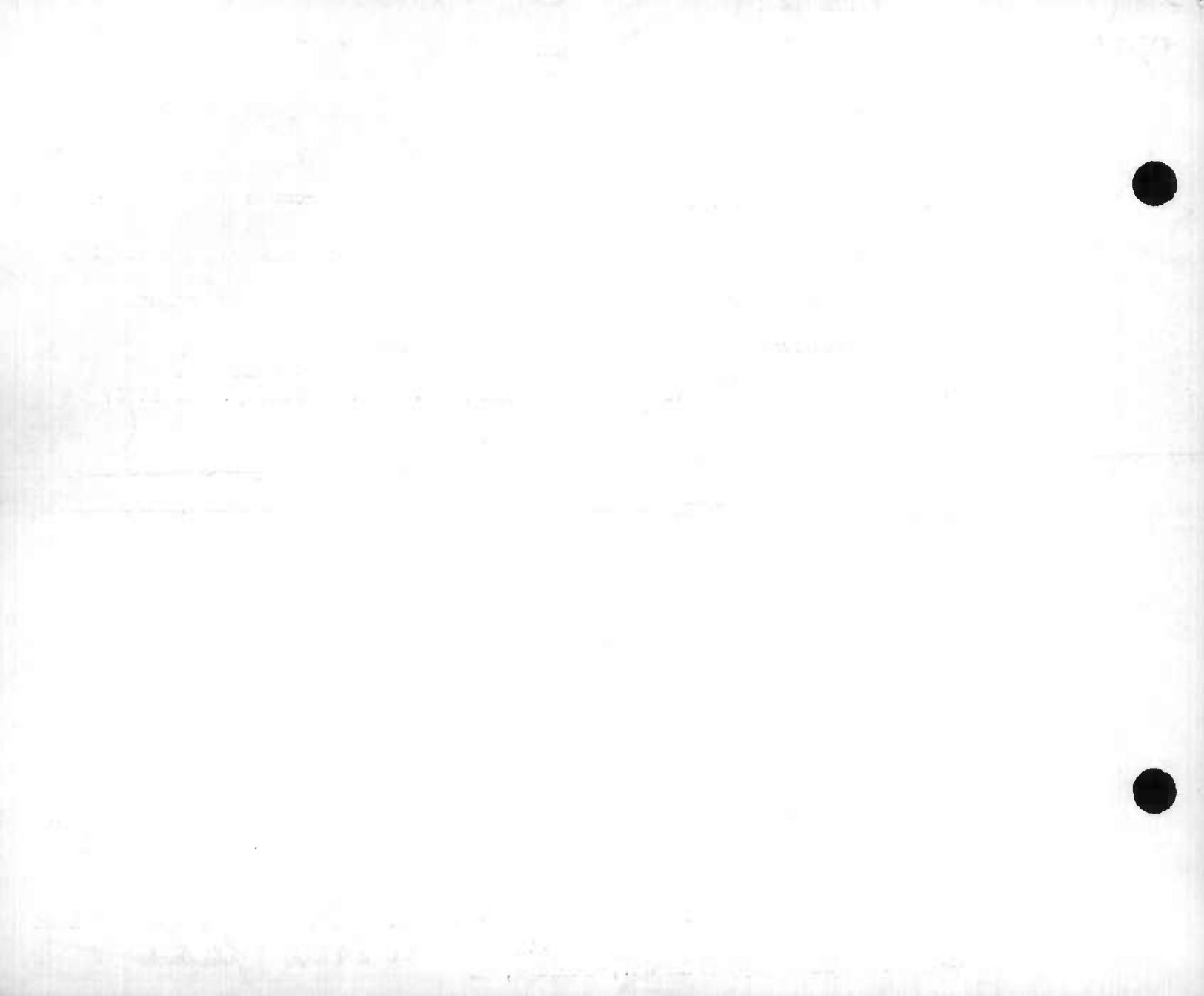
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

*Atherosclerotic heart disease*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>2-14-1986</i> to <i>2-21-1986</i> that (I) (we) lost saw the deceased alive on <i>2-20-1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Baskaran M.D.</i>				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>2.21.86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>D.S. BASKARAN, Jr.</i>				22e. ADDRESS <i>3455 Wilkens Ave Baltimore MD 21229</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>2/25/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Elkridge Howard Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Gary L. Kaufman</i> ADDRESS <i>5695 Main St., Elkridge, Md. 21227</i>				25. DATE REC'D. BY REGISTRAR <i>FEB 24 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Julian Davidson</i>	





070056

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 3 9 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) David I Helm			2a. DATE OF DEATH MONTH DAY YEAR 2 25 86			2b. HOUR M A			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 5 14 21		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10 CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. Gen. Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Toolmaker		12b. KIND OF BUSINESS OR INDUSTRY Auto		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Helm			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Alford			13e. STREET ADDRESS / ZIP CODE 3251 Normandy Woods Dr. 21043			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 229-07-8133		17 INFORMANT Arlene Helm			ADDRESS Same as #13		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 3rd</u> , 19 <u>84</u> , to <u>Feb. 25</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive <u>Feb 20</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Charles J. Wu.</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Feb. 25, 1986</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles J. Wu.			22e. ADDRESS 7845 Oakwood Road, Glen Bernie, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 2-28-86		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. MD		
24 FUNERAL DIRECTOR NAME ADDRESS MacNabb Funeral Home Catonsville, MD					25a. DATE REC'D. BY REGISTRAR MAR 7 1986				
					25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 0 5 3 9 5  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		M	
Winslow E. Hirth		2-22-86			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	white	MONTH DAY YEAR	70	IF UNDER 24 HRS	
				MONTHS DAYS	HOURS MIN.
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
USA	USA		Howard MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Columbia	Howard County General Hospital		Retired		U.S. Post Office
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE	
Md		Howard	Ellicott City	8458 Church Lane 21043	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Webster Hirth		Amelia K Keinz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		W.W. 11		Mrs Doris Hirth 8458 Church Lane 21043	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: BILAT CURAIS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		P.M. 19		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/13/86, 19 86, to 2/22, 19 86, that (I) (we) last saw the deceased alive on 2/22, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
M. B. C. A. I.		MD		2/23/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
M. B. C. A. I.		9051 BALTIMORE AVE EC MD 21043			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Feb 26' 86		Druid Ridge Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR			
Pikesville Balto., Maryland		FEB 24 1986			
24. FUNERAL DIRECTOR'S NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Harry H Witzke & Family Funeral Home Inc. 4112 Old Columbia Pike Ellicott City		FEB 24 1986		John Davidson-Rendall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits are to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 0 5 3 9 6

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LeRoy Robert Howie</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 12 86</b>			2b. HOUR <b>9:40</b> a			
3. SEX <b>Male</b>		4. RACE <b>caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Glassboro, N.J.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Savage</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9127 Baltimore Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MeatCutter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Safeway</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Savage</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>9127 Baltimore St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alexander Howie</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Custer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF NO, GIVE WAR NO.) <b>1943-1944</b>		17. INFORMANT <b>Loretta Howie</b>		ADDRESS <b>same as 13e</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pancreatic Adenocarcinoma - metastatic</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Chronic anemia, Chronic protein-calories malnutrition</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>April 19 85</b> , to <b>Feb 12 19 86</b> , that (I) (we) last saw the deceased alive on <b>Jan 22 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Jon M. Minford</b>				22c. DATE SIGNED <b>2-12-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jon R. Minford</b>				22e. ADDRESS <b>10806 Hickory Ridge Rd, Columbia, MD</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/14/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton P.E. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>FLECK F.H. INC.</b>		ADDRESS <b>7601 SANDY SPR. RD LAUREL, MD 20707</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 14 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Gordon-Randall</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please take these certificate papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

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*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMM - 17  
(VR A15 ME (5))1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6 05397  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST Joshua Raymond Johns			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2 26 1986			2b. HOUR M 3:55P			
3. SEX Male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Jan. 9 55	6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 2 26 1986			2d. HOUR M			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County, MD.						
10. CITY OR TOWN OF DEATH Clarksville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5900 Blk. Trotter Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane Operator		12b. KIND OF BUSINESS OR INDUSTRY Johnson				
13a. STATE Md.			13b. COUNTY Howard		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 20707 Crane 9680 G. Barrell House Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Joshua T. Johns			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Redmiles			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no						
16b. SOCIAL SECURITY NO. 212-64-2882			17. INFORMANT Bonnie Johns						ADDRESS Laurel, Md. 9526 N. Laurel Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound to head (handgun)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 1+ P.M. 2 26 86			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5900 Blk. Trotter Rd, Clarksville, Howard, MD.						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 2/27/86			
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.			ADDRESS 111 Penn St. Balto. MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/1/86		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P.G. Md.				
24. FUNERAL DIRECTOR NAME FLECK F.H. INC.			ADDRESS 7601 SANDY SPR. RD. LAUREL, MD.			25a. DATE REC'D. BY REGISTRAR MAR 4 1986			25b. REGISTRAR'S SIGNATURE 			







063013

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 3 9 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Gertrude E Kirkley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 22 86</b>			2b. HOUR <b>PM</b>				
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 24 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Columbia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.				
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Health Dep't</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Balto. City</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD</b>			13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6220 I foreland</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leigh Beaird</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude Rhinehart</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>212368598</b>		17. INFORMANT ADDRESS <b>M. Engle Ho. City. Gen Hosp ER</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory &amp; cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>2/22</b> , 19 <b>86</b> , to <b>2/22</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>2/22</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Gary Trade</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>2/22/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gary Trade</b>			22e. ADDRESS <b>11055 Little Potomac Pkwy Col. Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Feb 25 '86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balt. Md.</b>			
24. FUNERAL DIRECTOR'S NAME <b>Harry H Witzke &amp; Family Funeral Home</b>										
25a. DATE REC'D. BY REGISTRAR <b>4112 Old Columbia Pike Ellicott City</b>			25b. DATE REC'D. BY REGISTRAR <b>FEB 28 1986</b>			REGISTRAR'S SIGNATURE <b>John Anderson</b>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please deliver the above papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or if death was the result of an event, medical examiner must be notified and signed.

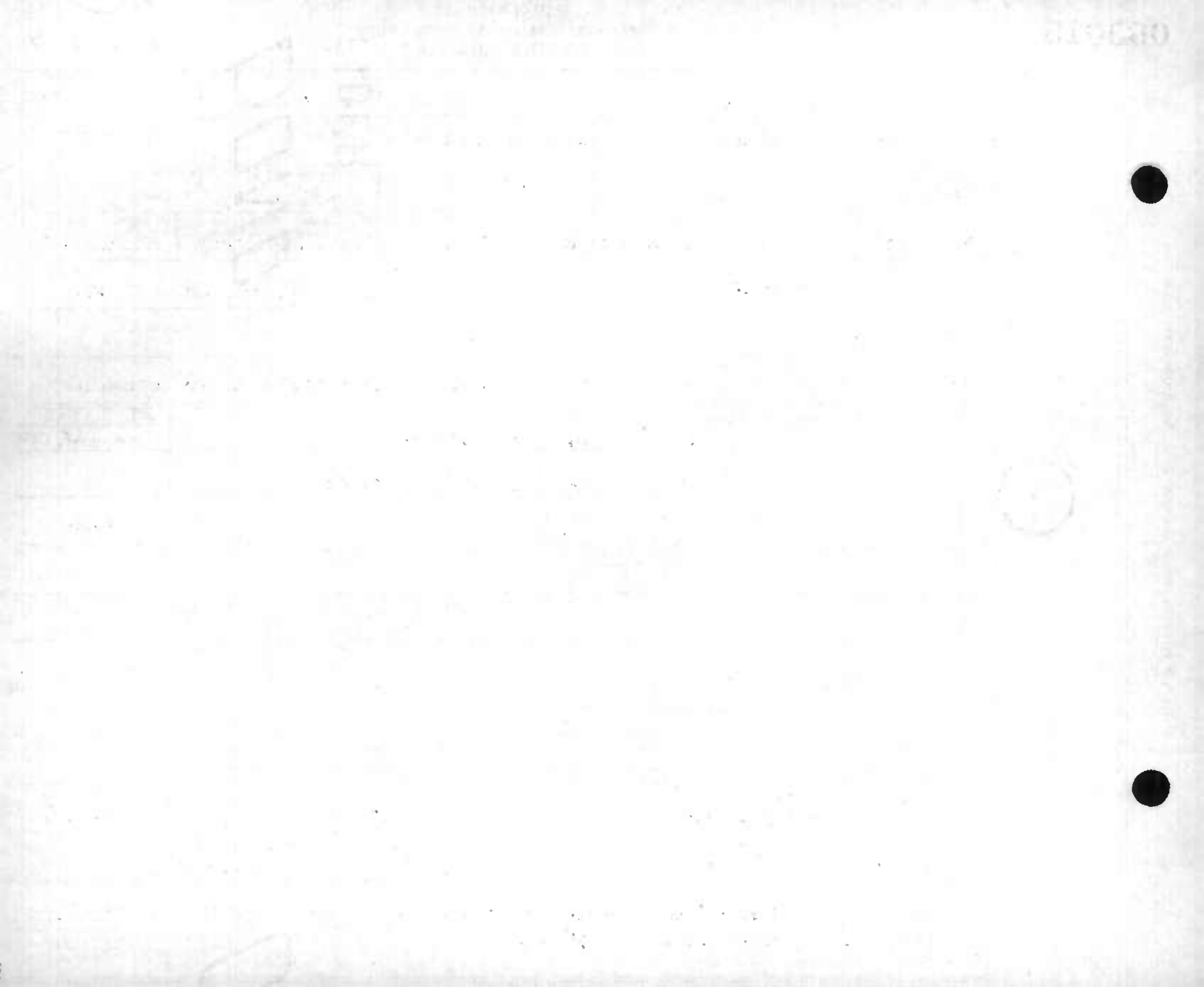
BP

DHMH - 16 60M 7/73  
(V R A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 3 9 9  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Betty J. Kopp		Female		White	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
June 3, 1932		53		MONTHS DAYS	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Ohio		Howard County		Columbia	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
9417 Mellenbrook Road 21045		Exec. Work. Secretary		Aluminum Co	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Howard		Columbia	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. INSIDE CITY LIMITS?	
John Gough		Jessie		YES <input type="checkbox"/> NO <input type="checkbox"/>	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)		17b. SOCIAL SECURITY NO.		17. INFORMANT	
No		214 30 6754		John Kopp 9417 Mellenbrook Rd Columbia Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. DUE TO, OR AS A CONSEQUENCE OF (b)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Cardio-respiratory arrest		Hypoxic failure 20 minutes		Immediate	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c)		1 yr.	
Ovarian Cancer					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
An. C. Waterfield		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		2/26/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
An. C. Waterfield		54 Agnes Hospital 900 Caton Ave Balto Md 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		Feb 26'86		Westview Memorial Pk	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Harry H Witzke & Family Funeral Home Inc. 4112 Old Columbia Pike Ellicott City		FEB 28 1986		John Davidson-Hendall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cationic detergent, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical record must be collected on a...

## MEDICAL CERTIFICATION

BP.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 4 0 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
STELLA		LABINSKI		February		14, 1986		4 <sup>03</sup> P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR	
FEMALE		WHITE		MONTH DAY YEAR 7 21 07		78 YRS		MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
PENNSYLVANIA		U.S.A.				HOWARD COUNTY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (TYPE OR PRINT FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
COLUMBIA		HOWARD COUNTY GENERAL HOSPITAL		HOUSE WIFE		OWN HOME			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE			
PENNSYLVANIA		WAYNE		BEACH LAKE		RD 1 P.O. BOX 26 18405		99999	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
STANLEY		JADZIEWICZ		NO		077-01-6521		SOPHIE R. WALLO 1002 SCOTT RD. DICKSON CITY PA.	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Diplococcus pneumoniae meningitis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Otitis media</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs 60 hrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)		Transvenous pacemaker							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from January 31, 1986, to February 14, 1986, that (I) (we) lost the deceased alive on Feb 14, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I we) did not leave the body after death.		22b. SIGNATURE William Parnes		22c. DATE SIGNED 2/14/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE OF DEATH		22g. REGISTRAR'S SIGNATURE			
WILLIAM PARNES		10085 Little Patuxent Pkwy Columbia, MD 21044		February 14, 1986		FEB 19 1986			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN) COUNTY STATE			
BURIAL		2/19/86		ST. MARY CEMETERY		DICKSON CITY PENNSYLVANIA			
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE FUNERAL HOME OF COLUMBIA 5555 TWIN KNOLLS ROAD COLUMBIA MARYLAND 21045		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
		FEB 19 1986		J. W. WITZKE					

1051

NEW YORK

RECEIVED



TO THE  
HONORABLE  
SPEAKER OF THE HOUSE OF REPRESENTATIVES  
WASHINGTON  
D.C.

DEAR SIR:

I have the honor to acknowledge the receipt of your letter of the 2nd inst. in relation to the matter of the proposed amendment to the Constitution of the State of New York, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Your obedient servant,  
J. B. [Signature]

041185

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6

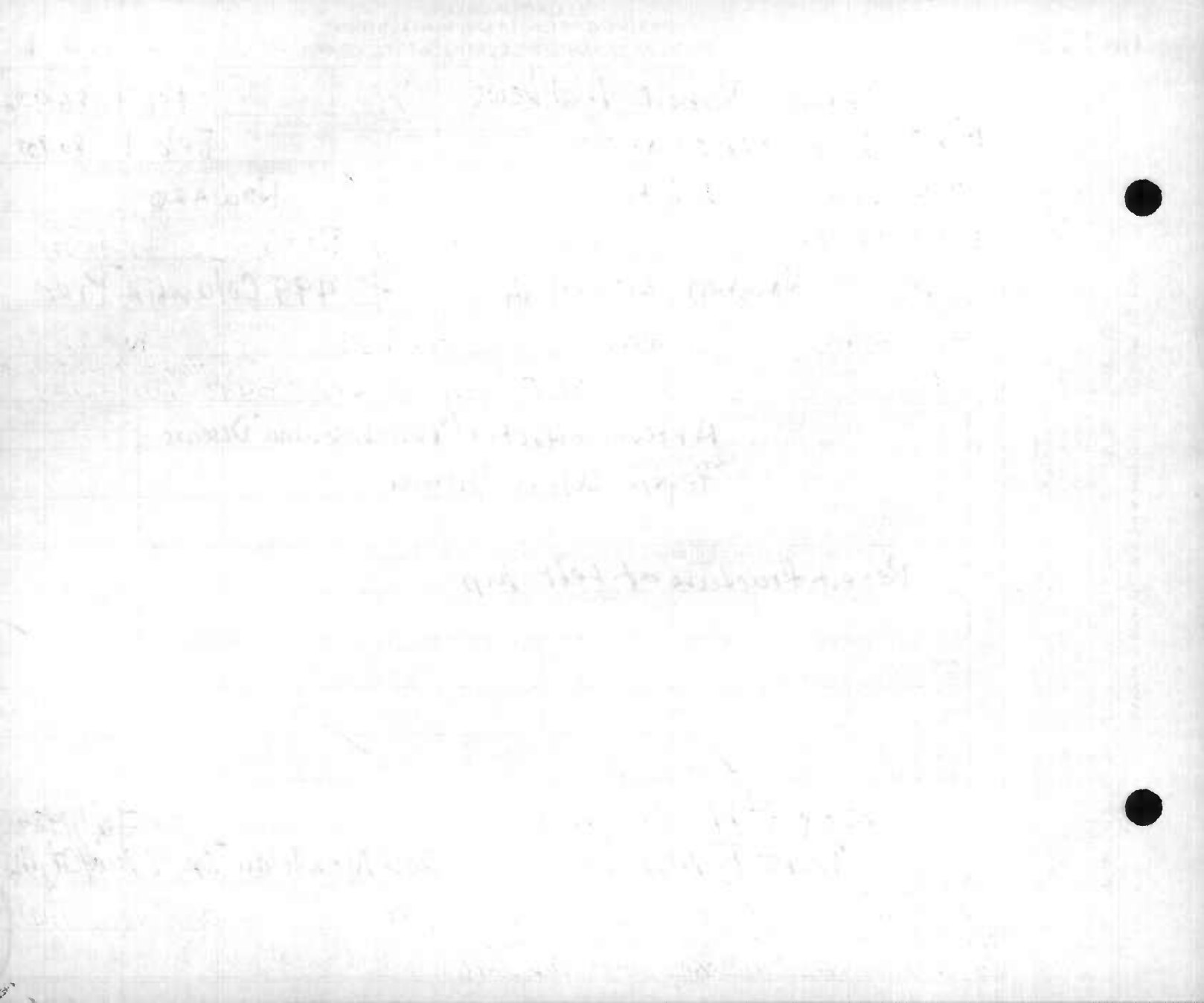
REG NO

0 5 4 0 1

1. DECEASED NAME (TYPE OR PRINT) <b>Charles Robert Matthews Sr.</b>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>Feb 1 19 86 901 AM</b>			2b. HOUR		
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>Feb</b> DAY <b>27</b> YEAR <b>09 77</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>77</b> YRS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	2c. DATE PRONOUNCED DEAD <b>Feb 1 19 86 901 AM</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD</b> MD.		
10. CITY OR TOWN OF DEATH <b>Ellicott City</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>499 Columbia Pike (Ellicott City)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>
13a. STATE <b>Mo</b>			13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>Ellicott City</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>499 Columbia Pike</b>		
14. FATHER'S NAME FIRST <b>Abraham</b> MIDDLE <b></b> LAST <b>Matthews</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Rachel</b> MIDDLE <b></b> LAST <b>Snell</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. <b>217-05-4455</b>		17. INFORMANT ADDRESS <b>Lottie M. Lewis BATHO. MD. 21229</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 887 IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Peptic Ulcer Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Recent Fracture of Left hip</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Bert F. Morton, M.D.</b>			TITLE (SPECIFY)			DATE SIGNED <b>Feb 1, 1986</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>BERT F. MORTON</b>			ADDRESS <b>2802 Montclair Dr. Ellicott City MD</b>					
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>			23b. DATE <b>2/5/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD.</b>	
24. FUNERAL DIRECTOR'S NAME <b>WALTER D. SONS FUNERAL HOME INC.</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 06 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Jane Davidson-Randall</b>	
25c. ADDRESS <b>2501 GAYNNS FALLS PKWY BATHO MD. 21216</b>								

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201





DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

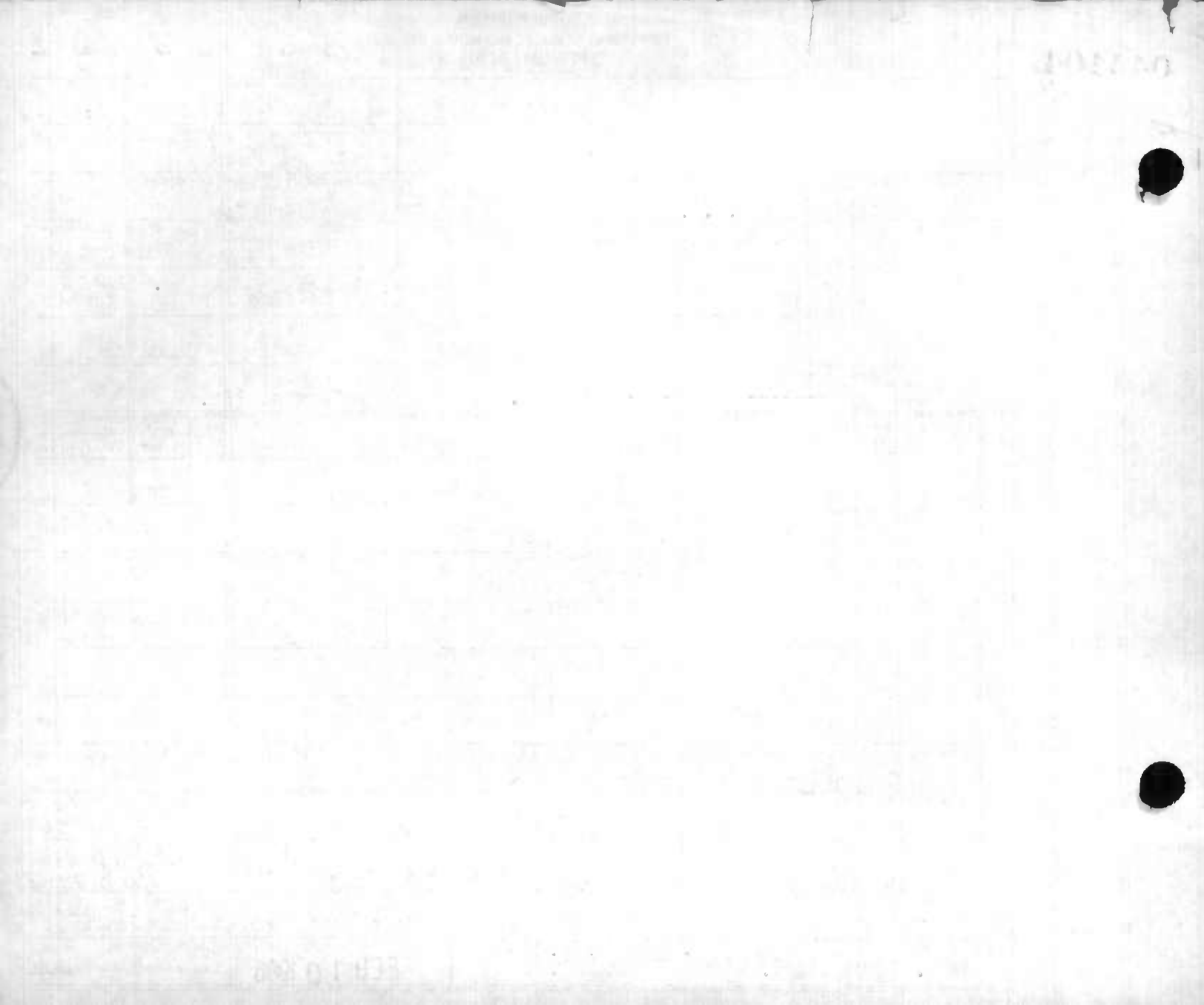
8605402  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ANNA MICHALSKI</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>2 9 1986</b>		2b. HOUR <b>3:20AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 29 1909</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lorien Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		13. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Micheal Bidun</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Solomie Celolick</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>137-03-3637</b>		17. INFORMANT ADDRESS <b>Mr. Eugene Bidun Same as 13e.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>urinary infection with sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alzheimers</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>days</b> <b>yrs</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Atherosclerosis Parkinsons</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1978</b> , 19 <b>86</b> , to <b>2/19/86</b> , that (I) (we) last saw the deceased alive on <b>2/7</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Helvin J. Gordon MD</b>		22c. DATE SIGNED <b>2/10/86</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Helvin J. Gordon MD</b>	
22e. ADDRESS <b>2000 Century Plaza Columbia MD 21046</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			
23b. DATE <b>2/13/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>East Hanover New Jersey</b>	
24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 10 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Johia Davidson-Randall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 of this certificate should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.



038033

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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(VR A15 ME (1))  
20M 4/82

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05403

DECEASED NAME (TYPE OR PRINT) <b>ARTHUR W. MYERS</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>02/02 1986</b>			2b. HOUR <b>2:5 P.M.</b>		
3. SEX <b>MALE</b>	4. RACE <b>CAUC</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>06 23 25 60 YRS.</b>	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	8. DATE PRONOUNCED DEAD <b>02/02 1986 2:5 P.M.</b>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD</b> MD		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S.A.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD</b> MD		
10. CITY OR TOWN OF DEATH <b>Columbia, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOWARD County GENERAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Insurance</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>
13a. STATE <b>MD.</b>		13b. COUNTY <b>HOWARD</b>	13c. CITY OR TOWN <b>Columbia</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>5009 East Lake Circle</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur W. Myers Sr</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Evans</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW11 216-20-1063</b>		17. INFORMANT ADDRESS <b>Mrs Irene Myers 5009 East Lake Circle</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Bert F. Morton</b>			TITLE (SPECIFY)			DATE SIGNED <b>Feb 2, 1986</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>BERT F. MORTON</b>			ADDRESS <b>2802 MONTCLAR DR. Ellicott City</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb 5, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crestlawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Marriottsville Howard Md</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Harry H Witzke 4112 Columbia Rd, Ellicott City Md</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 05 1986</b>		25b. REGISTRAR'S SIGNATURE		

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05404

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		26. HOUR			
LOTTIE VIRGINIA NICHOLSON								18		18		18		18		18		0200 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		21. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		24. HOUR	
F		B		Feb. 21/1986		67 YRS.		MONTHS		DAYS		HOURS		MIN		1		18		1200 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
MD				U.S.A.								HOWARD MD									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
LAUREL				9885 Harmony Lane																	
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS					
MD				Howard				Laurel				YES				9885 HARMONY LANE 20707					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																	
Arthur Hail				Elizabeth Smith																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS									
No				218-24-0152				Bertha Brown (sister)				same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____																		RESPIRATORY ARREST 1 year CHRONIC CARCINOMA OF THE ESOPHAGUS 1 year CHRONIC RENAL FAILURE 1 year			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): CHRONIC ALCOHOL ABUSE																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?									
MA				MA								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. MA 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) MA													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) MA				21f. LOCATION STREET MA CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE				M.D.				TITLE (SPECIFY)				DATE									
SCOTT T MAURER				DEPUTY				HO. COUNTY				2/3/86				COLUMBIA					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
SCOTT T MAURER				11085 LITTLE PATUXENT PKWY																	
23a. BURIAL, CREMATION, REMOVAL SPECIFY				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN				COUNTY STATE					
BURIAL				1-23-86				Mt Zion Cemetery				Laurel, Anne Arundel, MD									
24. FUNERAL DIRECTOR NAME				ADDRESS				25. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
George R. Snowden				246 N. Washington St. Rockville, MD 20850				FEB 4 1986				John Snowden, Registrar									

1. The first part of the report is a general  
 description of the project. It is a study of the  
 effects of the new law on the economy.  
 The second part is a detailed analysis of the  
 data. It shows that the law has had a  
 significant impact on the economy.  
 The third part is a conclusion. It states that  
 the law has been successful in achieving its  
 goals.

2. The first part of the report is a general  
 description of the project. It is a study of the  
 effects of the new law on the economy.  
 The second part is a detailed analysis of the  
 data. It shows that the law has had a  
 significant impact on the economy.  
 The third part is a conclusion. It states that  
 the law has been successful in achieving its  
 goals.

041176

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 4 0 5

REG. NO.

1. DECEASED NAME (Type or Print) <b>(The Rev.) Ernest A. Otto</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 2, 1986</b>			2b. HOUR <b>12:30 P.M.</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 9, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County, MD.</b>				
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Meth. Minister- Religion</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1016 Kent Avenue-21228</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Frederick Otto</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosabelle E. M. Reinhardt</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b>		17. INFORMANT ADDRESS <b>Catonsville, Md. 21228</b> <b>Mrs. Mildred A. Otto-1016 Kent Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. <b>Right middle lobe Central Tumor</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 76</b> , to <b>2/2 86</b> , that (I) (we) last saw the deceased alive on <b>1/5 86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>James J. Nolan</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>2/3/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J J NOLAN</b>					22e. ADDRESS <b>1 Mallard Hill Rd Balt Md 21229</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2/5/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn-Baltimore, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Sterling Funeral Estate, P.A.</b> <b>736 Edmondson Ave., Catonsville, Md. 21228</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 06 1986</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

February 2, 1962

Dear Mr. [illegible]

I am writing to you regarding the [illegible]

which was discussed at the [illegible]

meeting on [illegible]

and the [illegible]

of the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]

and the [illegible]



066082

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 05406

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>FFinlo C. Quine</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2-14-86</b>			2b. HOUR <b>9 A</b> M				
3 SEX <b>male</b>		4 RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 11 90</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>England</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.				
10 CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lorien Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>JOINER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		
13a. STATE <b>MD</b>			13b. COUNTY <b>P. G.</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>225 Patuxent Rd 26707</b>	
14a. FATHER'S NAME FIRST MIDDLE LAST <b>John Henry Quine</b>			14b. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ellen Cain</b>			15. ADDRESS <b>Laurel Md.</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>578-46-6669</b>		17. INFORMANT <b>A Grace Quine</b>		ADDRESS <b>225 Patuxent Rd.</b>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hiatal hernia with reflux</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Advanced age</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>one year</b> <b>years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <b>Jan 21</b> , 19 <b>86</b> , to <b>Feb 14</b> , 19 <b>86</b> , that (2) we last saw the deceased alive on <b>FEB 13</b> , 19 <b>86</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, if we (I did) (did not) view the body after death.										
22b. SIGNATURE <b>Dr. [Signature]</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/>		22c. DATE SIGNED <b>Feb 14, 1986</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb 17, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Md</b>			
24. FUNERAL DIRECTOR NAME <b>Donaldson Funeral Home, P.A. Md</b>			ADDRESS <b>Laurel</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 21 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP

CONFIDENTIAL

CONFIDENTIAL



CONFIDENTIAL

058105

DIVISION OF VITAL RECORDS, 301 WESTBOSTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 WESTBOSTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

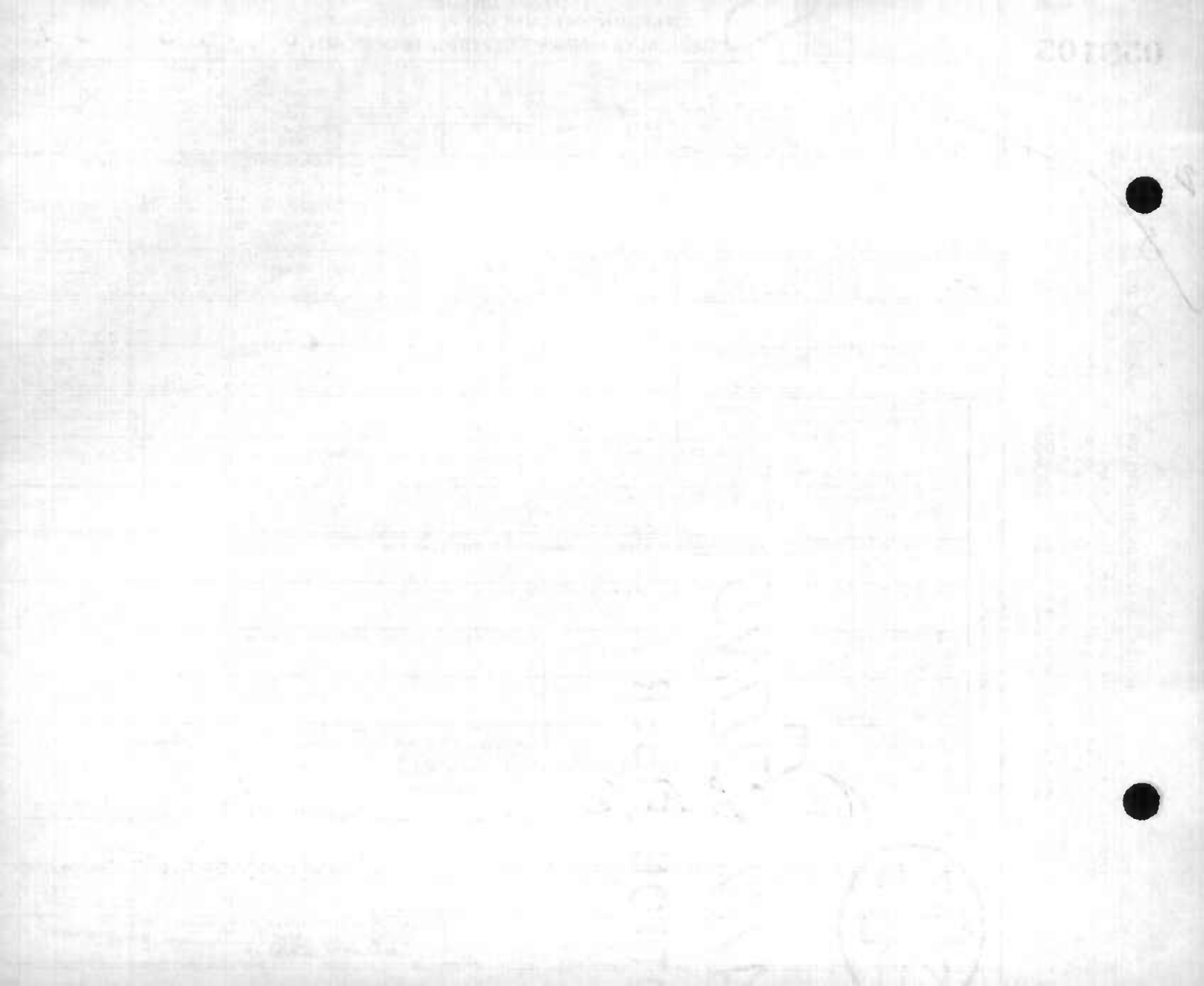
1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			20. DATE KNOWN OF DEATH			21. DATE OF ESTI MATED DEATH			22. DATE PRONOUNCED DEAD			23. HOUR				
Michael Elwyn Rawlings, Jr.												2 23 1986			2 23 1986			10:30 P M							
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			7. IF UNDER 1 YR.			8. IF UNDER 24 HRS.										
male			B			9 - 23 - 79			6 YRS.																
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH																
Maryland			U.S.A.			WIDOWED			Howard County																
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY																
Marriottsville			Route 99 East of Henryton Rd.			Student			----																
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS													
MD			Howard			Marriottsville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			11285 Old Frederick Road			21104										
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																						
Michael E. Rawlings, Sr.			Barbara Ann Dorsey																						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS																
NO			?			Michael Rawlings, Sr.			Sykesville, MD			21784													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:																									
IMMEDIATE CAUSE (a) Cardio pulmonary arrest																									
DUE TO, OR AS A CONSEQUENCE OF																									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																									
(b) Multiple injuries and trauma																									
DUE TO, OR AS A CONSEQUENCE OF																									
(c) car accident																									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																									
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?	
																								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH												21b. TIME OF INJURY												21c. HOW INJURY OCCURRED	
												HOUR A.M. MONTH DAY YEAR												(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
												P.M. 19													
21d. INJURY OCCURRED												21e. PLACE OF INJURY												21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>												STREET, FACTORY, FARM, ETC.)												STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																									
ACTUAL SIGNATURE												TITLE (SPECIFY)												DATE SIGNED	
Robert E. Ludicke												Assist.												2/23/86	
EXAMINER'S NAME												ADDRESS													
(TYPE OR PRINT)												Robert E. Ludicke, M.D.													
23a. BURIAL, CREMATION, REMOVAL												23b. DATE												23c. NAME OF CEMETERY OR CREMATORY	
BURIAL												2-27-86												West Liberty Cemetery	
24. FUNERAL DIRECTOR												25a. DATE REC'D. BY REGISTRAR												25b. REGISTRAR'S SIGNATURE	
Haight Funeral Home												FEB 25 1986												Jana M. ...	
NAME												ADDRESS													
Sykesville, MD																									

21043



038078

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in the funeral director's office. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 0 5 4 0 8  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sydney Hurlbut Renehan, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 2 - 4 - 86			2b. HOUR 5 p.m.				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 5 - 20 - 1902		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.				
10. CITY OR TOWN OF DEATH West Friendship		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1740 West Friendship Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Food Processor		12b. KIND OF BUSINESS OR INDUSTRY Self		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Howard		13c. CITY OR TOWN West. Friendship		13d. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1740 West Friendship Road 21784		
14 FATHER'S NAME FIRST MIDDLE LAST Aloysius H. Renehan				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Selby						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 820 02 7339		17 INFORMANT ADDRESS Mary E. Renehan West Friendship, MD						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.H.F.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>DIFFUSE HISTIOCYTIC LYMPHOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MDS.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HRS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>10-1</u> , 19 <u>79</u> , to <u>2-4</u> , 19 <u>86</u> , that (I) (we) lost the deceased above on <u>2-4</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Naci N. Buyukunsal</u>						22c. DATE SIGNED 2-4-86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Naci N. Buyukunsal, MD		
22e. ADDRESS 6212 Sykesville Rd Sykesville, Md 21784						22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2-7-86			23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City MD	
24. FUNERAL DIRECTOR NAME Harry W. Haight						25a. DATE REC'D. BY REGISTRAR FEB 05 1986		25b. REGISTRAR'S SIGNATURE <u>Wm. J. H. Jones</u>		



1980 FEB 02

044105

1- FOR  
STATE  
REGISTRAR

Harold A. Ridge Sr.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 0 5 4 0 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HAROLD A. RIDGE Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR HOUR <b>2 8 86 1130 P.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 12 11</b>	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>					
12b. KIND OF BUSINESS OR INDUSTRY <b>Proctor &amp; Gamble</b>					
13a. STREET ADDRESS / ZIP CODE <b>3426 Jay Drive Ellicott City Md. 21043</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Ridge</b>					
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethyl Lindenborn</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-03-6306</b>		17. INFORMANT ADDRESS <b>Josephine Ridge Same as 13c.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>advanced COPD/pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2-8-86</b> 19____, to <b>2-8-86</b> 19____, that (I) (we) lost <b>low</b> the deceased alive on <b>2-8-86</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did not view the body after death.					
22b. SIGNATURE <b>Richard D. Antonio</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>2-9-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD D ANTONIO</b>		22e. ADDRESS <b>14625 North RD Silver Spring MD 20904</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/12/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		24. FUNERAL DIRECTOR NAME <b>Leroy M. &amp; Russell C. Witzke Funeral Home</b>			
25a. DATE REC'D. BY REGISTRAR <b>FEB 10 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Leroy M. Witzke</b>			

1. The first part of the document is a list of names and addresses. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, 456 Elm St, and 789 Oak St.

2. The second part of the document is a list of items and their quantities. The items are: Apples, Bananas, and Oranges. The quantities are: 10, 5, and 3.

3. The third part of the document is a list of dates and times. The dates are: 1/1/2020, 2/1/2020, and 3/1/2020. The times are: 10:00 AM, 2:00 PM, and 5:00 PM.



051020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. 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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 4 1 0  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Regina A Riggs		2a. DATE OF DEATH MONTH DAY YEAR 2-13-86		2b. HOUR 1:45 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 05-24-15	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Gwynn Oak	
14. FATHER'S NAME FIRST MIDDLE LAST John J. Scanlon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Violet Murphy		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 219-40-6775		17. INFORMANT Daisy B. Riggs, 5713 2nd Avenue, 21227		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Bacterial Sinusitis	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Bacterial Sinusitis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/15/86 to 2/11/86, that (I) (we) last saw the deceased alive on 2/11/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) saw the body after death.					
22b. SIGNATURE Stacy Maurer MD		22c. DATE SIGNED 2/13/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAURER MD	
22e. ADDRESS 11085 LITTLE PATUXENT PKWY		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			
23b. DATE 2/15/86		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc., 4107 Wilkens Ave.		25a. DATE RECEIVED BY REGISTRAR FEB 18 1986		25b. REGISTRAR'S SIGNATURE [Signature]	



051172

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 0 5 4 1 1  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BER TYE E. Schwartz</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2-14-86</b>			2b. HOUR <b>10<sup>05</sup> AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 01 1885</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>100</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard Co. Gen. Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Practical Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Pikesville</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>620 Military Avenue 21208</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William L. Schwartz</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Anna Barbara Getz</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>217-40-3671</b>		17. INFORMANT <b>Mr. William W. Schwartz</b> ADDRESS <b>341 Liberty Road Sykesville, MD. 21784</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis and severe</b>		3 days	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Electrolyte Imbalance</b>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Compensated Heart Failure and Renal Failure**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/13</b> 19 <b>86</b> to <b>2/14</b> 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>2/13</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/14/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/19/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Baltimore MD</b>	
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b> ADDRESS <b>8728 Liberty Road Randallstown, MD. 21133</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 18 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

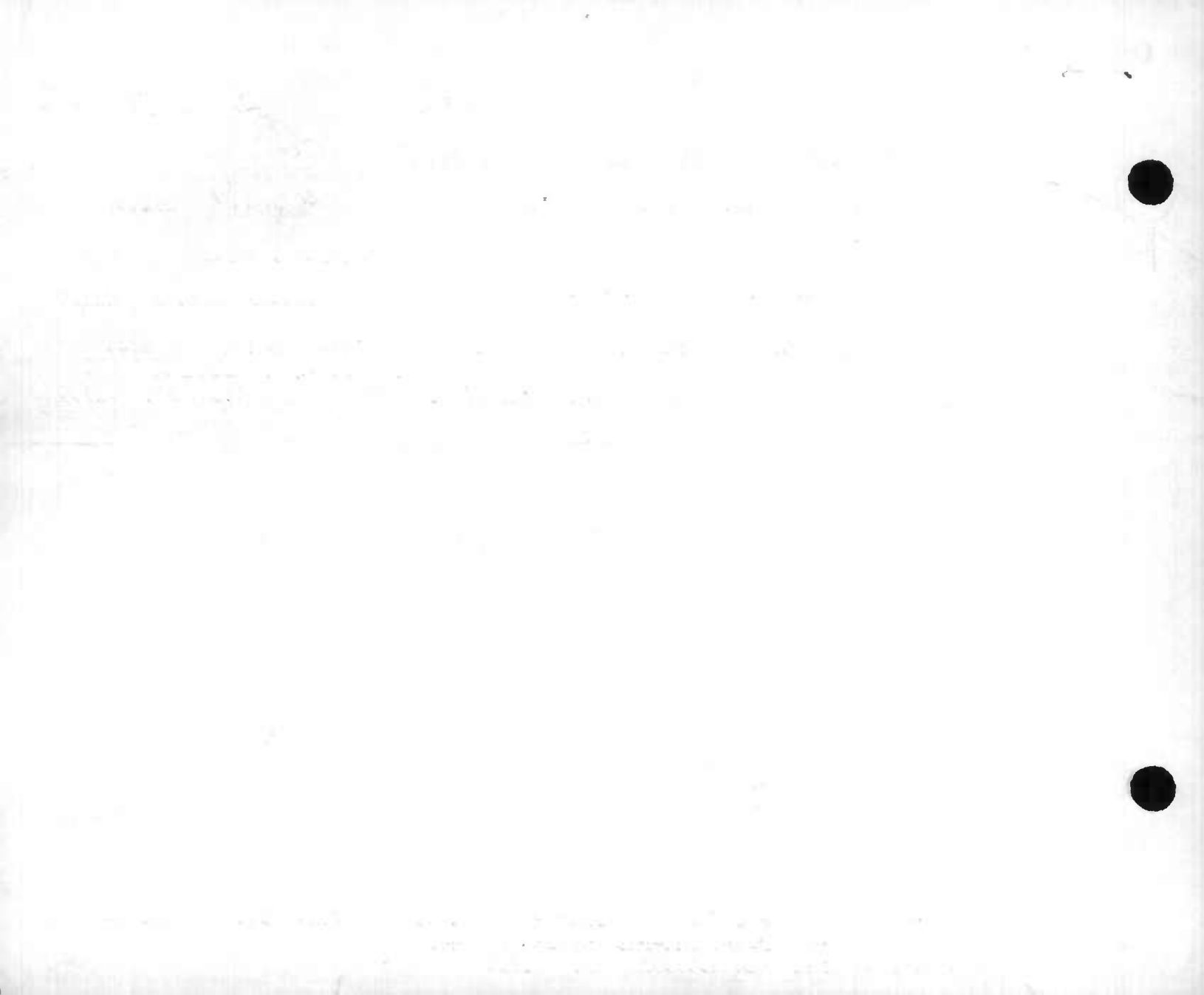
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

BP \_\_\_\_\_



038031

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 0 5 4 1 2  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SHAW HETTIE L SHAW</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2-4-86</b>		2b. HOUR <b>2 A</b> M.		
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8-30-96</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.	
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LORIEEN Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>21079</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Clarksville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Hartley</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Matilda Day</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>215-32-1601</b>		17. INFORMANT ADDRESS <b>Clarksville</b> <b>Richard W Shaw 13089 Tridelphia Mill Rd</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>CHRONIC CONGESTIVE HEART FAILURE</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <b>1/30</b> , 19 <b>86</b> , to <b>2/4</b> , 19 <b>86</b> , that (1) we last saw the deceased alive on <b>1/30</b> , 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) we (did not) view the body after death.							
22b. SIGNATURE <b>Emil J. Jackson M.D.</b>				DEGREE		22c. DATE SIGNED <b>2/4/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Emil J. Jackson M.D.</b>				22e. ADDRESS <b>5340 Ten Oaks Rd, Clarksville, MD 21025</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>2-5-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto Md</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Harry H Witzke 4112 Columbia Rd, Ellicott City Md</b>				25a. DATE RECEIVED BY REGISTRAR <b>FEB 05 1986</b>			
				25b. REGISTRAR'S SIGNATURE <b>Uma Davidson-Randall</b>			

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RECEIVED  
FEB 15 1952  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 0 5 4 1 3  
REG. NO

1. DECEASED NAME (TYPE OR PRINT) <b>Viola Leona Sheeler</b>			20. DATE OF DEATH MONTH DAY YEAR <b>Feb. 15, 1986</b>			2b. HOUR <b>5 22 AM</b>		
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 14, 1898</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>Columbia</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Horizon Hosp &amp; Sanitarium</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>			13c. CITY OR TOWN <b>Lutherville</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Peterson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jennie Williams</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		
16b. SOCIAL SECURITY NO. <b>216-07-5586</b>			17. INFORMANT <b>Mrs. Vivian V. Howard, 12 Beehive Pl.</b>			ADDRESS <b>Apt. D</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE Cause (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF <b>CHRONIC FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ORGANIC BRAIN SYN. GI-BLEED.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ORGANIC BRAIN SYN. GI-BLEED.</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>C. H. [Signature]</b>			DEGREE <b>MD</b>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>IMTIAZ H. CHANDIO</b>			22e. ADDRESS <b>10798 HICKORY RIDGE ROAD COLUMBIA MD 21046</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2-17-86</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Poplar U. Meth. Ch. Cem.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>			24. FUNERAL DIRECTOR NAME <b>Martin D. Lawson</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 18 1986</b>		
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>								

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 otherwise injury, or other traumatic event, the medical examiner must file a note on this subject.

Howard County

Howard County

Howard County

Howard County

Howard County

Howard County

Howard County

Howard County



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FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 05414  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Joseph Ernest Smith			MONTH DAY YEAR 2 - 4 - 86			9:20 A M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	Cauc.	MONTH DAY YEAR 9 3 04		81 YRS		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY	
Maryland	U.S.A.			Howard County MD.			Civil Service	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Ellicott City	Bon Secours Extended Care Facility			Postmaster				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Howard	Ellicott City		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8422 Church Lane Rd. 21043	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
John E. Smith			Inez Mae Jarboe					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO			212-09-4435		Lois V. Warden 8422 Church Lane Rd. 21043			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic renal insufficiency due to nephrosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
				4/16 19 81 to 2/4 19 86				
22a. I certify that (I) (this hospital) attended the deceased from <u>2/4 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death)								22c. DATE SIGNED
22b. SIGNATURE OF PHYSICIAN <u>Herbert J. Levickas</u> M.D.								2/4/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
Dr. Herbert Levickas				5404 East Drive, Balto., Md. 21227				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		2/6/86		St. Michael Ch. Cem.		Ridge St. Mary's Md.		
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Hubbard Funeral Home, Inc., 4107 Wilkens Ave. 21229				FEB 05 1986		John Davidson-Randall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2, and mail them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 05415

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>IRVIN</b> <b>M.</b> <b>SPICER</b>			20. DATE OF DEATH MONTH <b>2</b> DAY <b>22</b> YEAR <b>86</b> 2b HOUR <b>6:24 AM</b>	
3. SEX <b>Male</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH <b>09</b> DAY <b>22</b> YEAR <b>29</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY</b> MD.
10. CITY OR TOWN OF DEATH <b>Columbia</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard Co. General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SUPERINTENDENT</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>ROAD DEPT.</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>HOWARD</b>	13c. CITY OR TOWN <b>ELLICOTT CDTY</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST <b>WILLIAM</b> MIDDLE <b>J.</b> LAST <b>SPICER</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ETHEL</b> MIDDLE <b>M.</b> LAST <b>THOMAS</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>4/48-8/51</b>	17. INFORMANT <b>MS. ORA J. SPICER</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE RESPIRATORY ARREST FOLLOWED</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ADENOCARCINOMA DE LUNGS METASTATIC</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 HRS</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>2/27</b> , 19 <b>86</b> , to <b>2/22</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>2/21</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Krishna P. Kumar</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2.22.86</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KRISHNA P. KUMAR</b>		22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>25 FEB 86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE MEM. PK.</b>	23d. LOCATION (CITY OR TOWN) <b>ELKRIDGE</b> COUNTY <b>HOWARD</b> STATE <b>MD.</b>	
24. FUNERAL DIRECTOR NAME <b>SLACK FUNERAL HOME</b>		ADDRESS <b>ELLICOTT CITY, MD 21043</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1986</b>
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

LC 0380

WHEATON

057152

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 0 5 4 1 6

1. DECEASED NAME (TYPE OR PRINT) Calvin T. Tittsworth		2a. DATE OF DEATH MONTH DAY YEAR February 20, 1986		2b. HOUR M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR November 16, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.	
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Howard County General Hospital		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Carroll	13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 440 Gaither Road 21784
14. FATHER'S NAME FIRST MIDDLE LAST Roger H. Tittsworth		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Moxley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Mrs Margaret Tittsworth 440 Gaither Rd 21784	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/16</u> , 19 <u>86</u> , to <u>2/20</u> 19 <u>86</u> , that (I) (we) lost <u>the deceased alive</u> <u>above</u> <u>the</u> <u>body</u> <u>after</u> <u>death</u> , and that in <u>my</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE <i>John C. Healy</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John C. HEALY		22e. ADDRESS 1311 Francis Ave - Ball, Md 21223			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Feb 24, 1986		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City Howard Maryland		23e. DATE REC'D. BY REGISTRAR FEB 24 1986			
24. FUNERAL DIRECTOR NAME Inc Harry H Witzke & Family Funeral Home 4112 Old Columbia Pike Ellicott City		25. REGISTRAR'S SIGNATURE <i>Wendell</i>			

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical certificate should be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 4 1 7

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
EDNA Lenoir TODD		2 / 25 / 1986		3 25 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR MONTHS DAYS	
Female	White	1 6 1900	86		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Md	U.S.A.		Howard MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Columbia	Howard County General Hosp		Telephone Oper.		Comm. Tele.
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE	
MD	Howard	Ellicott		12117 Frederick Rd 21043	
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. ADDRESS		
John Thomas Bucy	Ida Katherine Maruin		12117 Frederick Rd. 21043		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			
No	213-50-1190	Ms. Betty Saunders			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardio-pulmonary resuscitation					
DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia					
DUE TO, OR AS A CONSEQUENCE OF (c) sepsis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestive heart failure, s/p pacemaker placement.					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
WOUND AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22a. I certify that (I) (this hospital) attended the deceased from 2/24, 19 86, to 2/25, 19 86, that (I) (we) last saw the deceased alive on 2/25, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
Charles E. Sheehan M.D.			2/25/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
Charles E. Sheehan M.D.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	2-28-86	Meadowridge Mem.	Elkridge Howard Md.		
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Slack Funeral Home	Box 2680		EEB 27 1986		
ADDRESS					
Ellicott City, Md. 21043					

070330

RECEIVED 10/10/03

10/10/03

10/10/03





049070

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 0 5 4 1 8  
REG. NO.

DECEASED NAME (TYPE OR PRINT) Charles Glenn Tolley			2a. DATE OF DEATH MONTH DAY YEAR 02 12 86		2b. HOUR 9 20 AM	
1. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 05 20 27		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.		
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Marine Corps Eng.		12b. KIND OF BUSINESS OR INDUSTRY Self-Emp.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Howard	13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2822 Fox Hound Rd. 21043

FATHER'S NAME FIRST MIDDLE LAST Charles Prestan Tolley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Retha (Hankla) Flippen		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) —	17. INFORMANT ADDRESS Ms. Angeline C. Tolley 2822 Fox Hound Rd. Ellicott City, Md. 21043			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Simult.</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypotension</u>		Hours
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Esophageal Varices Bleed</u>		days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Hepatic Cirrhosis</u>			
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19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from <u>19 75</u> to <u>02/12</u> 19 <u>86</u> , that (I/we) lost saw the deceased alive on <u>02/12</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.			
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22b. SIGNATURE <u>B.H. Minchew</u>	DEGREE <u>M.D.</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>02/12/86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>B.H. Minchew</u>		22e. ADDRESS <u>4051 Balt. Natl. Pike Ellicott City, Md. 21043</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>2-14-86</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cem.</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Ellicott City Howard Md.</u>
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24. FUNERAL DIRECTOR NAME <u>Slack Funeral Home</u>	ADDRESS <u>Box 268 Ellicott City, Md. 21043</u>	25a. DATE REC'D. BY REGISTRAR <u>EB 13 1986</u>	25b. REGISTRAR'S SIGNATURE <u>J. Davidson</u>
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DIVISION OF VITAL RECORDS, 701 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and submit burial within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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POSTION 2001

WATFALL

055125

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8605419  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ANNE S. Weiss</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>2-14-86</b>		2b. HOUR <b>12:40 A.M.</b>	
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 28 19</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard Co.</b> MD	
10. CITY OR TOWN OF DEATH <b>Columbia</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOWARD COUNTY GEN'L. HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>HOWARD</b>	13c. CITY OR TOWN <b>Columbia</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ADOLPH SCHIFFMAN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CLARA PINELAS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No - Husband WWII</b>		16b. SOCIAL SECURITY NO. <b>109-09-70484</b>		17. INFORMANT ADDRESS <b>Belo Weiss 7080 Cradle Rock Way #920 Columbia, MD</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Upper Airway Obstruction</b>			
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Adenocarcinoma of breast-metastatic</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>E. coli sepsis, Chronic Anemia, Peritoneal carcinomatosis</b>			

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **Nov 1** 19 **85**, to **Feb 14** 19 **86**, that (I) (we) lost  
saw the deceased alive on **Feb 13** 19 **86** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <b>Jon Minford</b>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>2/14/86</b>
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jon Minford</b>	22e. ADDRESS <b>10806 Hickory Ridge Rd Columbia MD 21044</b>
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>2-16-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Vet.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>GARRISON BALTO. MD</b>
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24. FUNERAL DIRECTOR NAME <b>HEBREW MEMORIAL F.H. - 1100 REISTERSTOWN RD</b>	25a. DATE REC'D. BY REGISTRAR <b>FEB 19 1986</b>	25b. REGISTRAR'S SIGNATURE <b>J. Minford</b>
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26. TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.	27. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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28. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.
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29. MEDICAL CERTIFICATION
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30. BP
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1000

0411179

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

8 6 0 5 4 2 0

1- FOR  
STATE  
REGISTRAR

Jerome

E. Weller

REG. NO.

1. DECEASED NAME

FIRST

MIDDLE

LAST

WELLER, JEROME

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

2/5/86

7:30 AM

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH

DAY

YEAR

March 26, 1910

6. AGE (IN YEARS LAST BIRTHDAY)

75

7. IF UNDER 1 YEAR

IF UNDER 1 YEAR

8. IF UNDER 1 YEAR

IF UNDER 1 YEAR

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Balto. Cnty, Md.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8

MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

Howard County, MD

10. CITY OR TOWN OF DEATH

Columbia

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Howard County Gen. Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

U.S. Govt. Internal Revenue

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md

13b. COUNTY

Howard

13c. CITY OR TOWN

Elkridge

13d. INSIDE CITY LIMITS?

YES

NO

X

13e. STREET ADDRESS / ZIP CODE

4915 Landing Rd. 21227.

14. FATHER'S NAME

Frederick George

Weller

15. MOTHER'S MAIDEN NAME

Margaret

---

O'Brien

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

WW II

17. INFORMANT

4915 Landing Rd. - Elkridge, Md. 21227. Mrs. Elizabeth B. Weller

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute pulmonary edema

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1h

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

acute bradycardia

1h

DUE TO, OR AS A CONSEQUENCE OF

(c)

Acute myocardial infarct

48h

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

Ischemic Cardiomyopathy

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES

NO

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES

NO

X

21a. ACCIDENT WAS UNDERLYING

21b. TIME OF INJURY

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

HOUR A.M. MONTH DAY YEAR

P.M.

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

WHILE AT WORK

NOT WHILE AT WORK

CITY OR TOWN

COUNTY

STATE

22a. certify that (I) (this hospital) attended the deceased from

19

to

19

that (I) (we) last

saw the deceased alive on

above, (I) (we) did (did not) view the body after death.

and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

22f. PHYSICIAN'S NAME (TYPE OR PRINT)

22g. PHYSICIAN'S NAME (TYPE OR PRINT)

22h. PHYSICIAN'S NAME (TYPE OR PRINT)

22i. PHYSICIAN'S NAME (TYPE OR PRINT)

22j. PHYSICIAN'S NAME (TYPE OR PRINT)

22k. PHYSICIAN'S NAME (TYPE OR PRINT)

22l. PHYSICIAN'S NAME (TYPE OR PRINT)

22m. PHYSICIAN'S NAME (TYPE OR PRINT)

22n. PHYSICIAN'S NAME (TYPE OR PRINT)

22o. PHYSICIAN'S NAME (TYPE OR PRINT)

22p. PHYSICIAN'S NAME (TYPE OR PRINT)

22q. PHYSICIAN'S NAME (TYPE OR PRINT)

22r. PHYSICIAN'S NAME (TYPE OR PRINT)

22s. PHYSICIAN'S NAME (TYPE OR PRINT)

22t. PHYSICIAN'S NAME (TYPE OR PRINT)

22u. PHYSICIAN'S NAME (TYPE OR PRINT)

22v. PHYSICIAN'S NAME (TYPE OR PRINT)

22w. PHYSICIAN'S NAME (TYPE OR PRINT)

22x. PHYSICIAN'S NAME (TYPE OR PRINT)

22y. PHYSICIAN'S NAME (TYPE OR PRINT)

22z. PHYSICIAN'S NAME (TYPE OR PRINT)

22aa. PHYSICIAN'S NAME (TYPE OR PRINT)

22ab. PHYSICIAN'S NAME (TYPE OR PRINT)

22ac. PHYSICIAN'S NAME (TYPE OR PRINT)

22ad. PHYSICIAN'S NAME (TYPE OR PRINT)

22ae. PHYSICIAN'S NAME (TYPE OR PRINT)

22af. PHYSICIAN'S NAME (TYPE OR PRINT)

22ag. PHYSICIAN'S NAME (TYPE OR PRINT)

22ah. PHYSICIAN'S NAME (TYPE OR PRINT)

22ai. PHYSICIAN'S NAME (TYPE OR PRINT)

22aj. PHYSICIAN'S NAME (TYPE OR PRINT)

22ak. PHYSICIAN'S NAME (TYPE OR PRINT)

22al. PHYSICIAN'S NAME (TYPE OR PRINT)

22am. PHYSICIAN'S NAME (TYPE OR PRINT)

22an. PHYSICIAN'S NAME (TYPE OR PRINT)

22ao. PHYSICIAN'S NAME (TYPE OR PRINT)

22ap. PHYSICIAN'S NAME (TYPE OR PRINT)

22aq. PHYSICIAN'S NAME (TYPE OR PRINT)

22ar. PHYSICIAN'S NAME (TYPE OR PRINT)

22as. PHYSICIAN'S NAME (TYPE OR PRINT)

22at. PHYSICIAN'S NAME (TYPE OR PRINT)

22au. PHYSICIAN'S NAME (TYPE OR PRINT)

22av. PHYSICIAN'S NAME (TYPE OR PRINT)

22aw. PHYSICIAN'S NAME (TYPE OR PRINT)

22ax. PHYSICIAN'S NAME (TYPE OR PRINT)

22ay. PHYSICIAN'S NAME (TYPE OR PRINT)

22az. PHYSICIAN'S NAME (TYPE OR PRINT)

22ba. PHYSICIAN'S NAME (TYPE OR PRINT)

22bb. PHYSICIAN'S NAME (TYPE OR PRINT)

22bc. PHYSICIAN'S NAME (TYPE OR PRINT)

22bd. PHYSICIAN'S NAME (TYPE OR PRINT)

22be. PHYSICIAN'S NAME (TYPE OR PRINT)

22bf. PHYSICIAN'S NAME (TYPE OR PRINT)

22bg. PHYSICIAN'S NAME (TYPE OR PRINT)

22bh. PHYSICIAN'S NAME (TYPE OR PRINT)

22bi. PHYSICIAN'S NAME (TYPE OR PRINT)

22bj. PHYSICIAN'S NAME (TYPE OR PRINT)

22bk. PHYSICIAN'S NAME (TYPE OR PRINT)

22bl. PHYSICIAN'S NAME (TYPE OR PRINT)

22bm. PHYSICIAN'S NAME (TYPE OR PRINT)

22bn. PHYSICIAN'S NAME (TYPE OR PRINT)

22bo. PHYSICIAN'S NAME (TYPE OR PRINT)

22bp. PHYSICIAN'S NAME (TYPE OR PRINT)

22bq. PHYSICIAN'S NAME (TYPE OR PRINT)

22br. PHYSICIAN'S NAME (TYPE OR PRINT)

22bs. PHYSICIAN'S NAME (TYPE OR PRINT)

22bt. PHYSICIAN'S NAME (TYPE OR PRINT)

22bu. PHYSICIAN'S NAME (TYPE OR PRINT)

22bv. PHYSICIAN'S NAME (TYPE OR PRINT)

22bw. PHYSICIAN'S NAME (TYPE OR PRINT)

22bx. PHYSICIAN'S NAME (TYPE OR PRINT)

22by. PHYSICIAN'S NAME (TYPE OR PRINT)

22bz. PHYSICIAN'S NAME (TYPE OR PRINT)

22ca. PHYSICIAN'S NAME (TYPE OR PRINT)

22cb. PHYSICIAN'S NAME (TYPE OR PRINT)

22cc. PHYSICIAN'S NAME (TYPE OR PRINT)

22cd. PHYSICIAN'S NAME (TYPE OR PRINT)

22ce. PHYSICIAN'S NAME (TYPE OR PRINT)

22cf. PHYSICIAN'S NAME (TYPE OR PRINT)

22cg. PHYSICIAN'S NAME (TYPE OR PRINT)

22ch. PHYSICIAN'S NAME (TYPE OR PRINT)

22ci. PHYSICIAN'S NAME (TYPE OR PRINT)

22cj. PHYSICIAN'S NAME (TYPE OR PRINT)

22ck. PHYSICIAN'S NAME (TYPE OR PRINT)

22cl. PHYSICIAN'S NAME (TYPE OR PRINT)

22cm. PHYSICIAN'S NAME (TYPE OR PRINT)

20% cotton

Jerome E. Weller

2/28/80

Weller - Jerome

White March 26, 1910

Bellevue, Ont., U.S.A. x  
Columbia  
Ad. Howard - Alameda x  
1915 Landing No. 21227

1915 Landing No. 21227  
1915 Landing No. 21227  
1915 Landing No. 21227

506 Exchange Ave., Cincinnati, Ohio 45202  
Tel. 212-00-2200  
Bureau of Census - Washington, D.C.

066137

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 05421

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FRANK WHITAKER Whitaker</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 11 86</b>			2b. HOUR <b>11 56 AM</b>							
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 11 33</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS <b>7</b>		8. IF UNDER 23 HRS HOURS MIN. <b>7</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY MD.</b>							
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOWARD COUNTY GEN. HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mail Handler</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Wash Terminal</b>				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>M.D.</b>						13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>7080 Cradle Rock Way 21045</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Whitaker</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Etta Draughn</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-22-6852</b>		17. INFORMANT <b>Deborah Whitaker</b>				ADDRESS <b>5866 Stevens Forest Road Columbia, Maryland 21045</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia with Septic Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple Myeloma</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Acute Renal Failure, Diarrhea, Chronic anemia</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <b>July 19 85</b> , to <b>Feb 11 19 86</b> , that (I) (we) last saw the deceased alive on <b>Feb 11 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Jon Minford</b>						DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>2-11-86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jon K. Minford</b>						22e. ADDRESS <b>10806 Hickory Ridge Rd, Columbia, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>2/14/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landover Prince George's MD</b>			
24. FUNERAL HOME <b>ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 24 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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ROLLING TUNNEL HOME, INC.  
FOR DEPOSIT ONLY



055122

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86  
REG. NO.

054222

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES ROBERT WHITE SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 17, 1986</b>			2b. HOUR <b>11:00 AM</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>September 22, 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.					
12. CITY OR TOWN OF DEATH <b>Ellicott City</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4713 Roundhill Road</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self Employed</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Attorney</b>			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>Maryland</b>			16b. COUNTY <b>Howard</b>		16c. CITY OR TOWN <b>Ellicott City</b>		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE <b>4713 Roundhill Road 21043</b>		
17. FATHER'S NAME FIRST MIDDLE LAST <b>John J. White</b>			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Doretta Isabel Morrison</b>			19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes Korean</b>					
20. SOCIAL SECURITY NO. <b>216-22-4254</b>			21. INFORMANT <b>Patrick A. O'Doherty</b>			22. ADDRESS <b>1011 Fidelity Bld. Baltimore, MD. 21201</b>					
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC SQUAMOUS CARCINOMA OF TONSIL</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b> <b>16 mos</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
24. DATE OF OPERATION <b>9/9/86</b>			25. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>19</b>			26. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
31. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			33. LOCATION STREET CITY OR TOWN COUNTY STATE					
34. I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 20, 1985</b> to <b>FEB. 17, 1986</b> , that (I) (we) last saw the deceased alive on <b>JANUARY 16, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
35. SIGNATURE <b>William P. McGuire</b>						36. DEGREE <b>MD</b>		37. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		38. DATE SIGNED <b>2-18-86</b>	
39. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William McGuire M.D.</b>						40. ADDRESS <b>Room 128 John Hopkins Hospital, Baltimore, MD.</b>					
41. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			42. DATE <b>2/20/86</b>		43. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		44. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		45. FUNERAL DIRECTOR NAME <b>Lero M. &amp; Russell C. Witzke</b>		
46. ADDRESS <b>1630 Edmondson Avenue, Catonsville, MD. 21228</b>						47. DATE RECD. BY REGISTRAR <b>FEB 19 1986</b>		48. REGISTRAR'S SIGNATURE <b>James H. Anderson</b>			

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 4 2 3  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		BENNY JOE WILSON		February 27, 1986		11:40A <sub>M</sub>	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		November 5, 1936		49 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Tennessee		U.S.A.				Howard County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Columbia		5165 Evangeline Way		Retired Printer		S.S.A.	
13a. STATE				13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE	
Maryland				Howard Columbia		5165 Evangeline Way 21044	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
James Wilson				Jessie Marshall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No		372-36-7553		Rufus Wilson		Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ureteral Obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of Rectum - metastatic</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Bowel obstruction, Chronic anemia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>January 1985</u> to <u>Feb 27 1986</u> , that (I) (we) lost saw the deceased alive on <u>Feb 26 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John Minford</u>				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Minford M.D.				22e. ADDRESS 10806 Hickory Ridge Rd Columbia MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		2/28/86		Westview Crematory		Catonsville MD.	
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 5555 Twin Knolls Road, Columbia, MD. 21045				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>	
				FEB 28 1986			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.



056117

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 0 5 4 2 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Annie C. Young</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>2/16/86</i>		2b. HOUR MIN. <i>10<sup>07</sup> AM</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12/13/95</i>	
6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>90</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Grand Forks, N.D.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard</i>		MD.			
10. CITY OR TOWN OF DEATH <i>Columbia</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Howard County General</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>					
13a. STATE <i>Md.</i>		13b. COUNTY <i>Howard</i>		13c. CITY OR TOWN <i>Clarksville, Md.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ed Spicer</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Leticia Maria unknown</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>576-03-9388</i>		17. INFORMANT ADDRESS <i>13597 Highland Rd.</i> <i>Hazel Coffman Clarksville, Md. 21029</i>	

18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST - ASYSTOLE</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Seconds</i>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last b) <i>CONGESTIVE HEART FAILURE</i>		<i>hours</i>	
DUE TO, OR AS A CONSEQUENCE OF c) <i>PROBABLE SEPSIS</i>		<i>hours to days</i>	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Renal failure, Supraventricular tachycardia</i>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>2/15/86</i> to <i>2/16/86</i> , that (I) (we) last saw the deceased alive on <i>2/16/86</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Stephen A. Valenti</i>		22c. DATE SIGNED <i>2/16/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>STEPHEN A. VALENTI</i>		22e. ADDRESS <i>Howard County General Hospital</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2/20/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Malta Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Malta Phillips Montana</i>	
24. FUNERAL DIRECTOR NAME <i>FLECK F.H. INC.</i>		ADDRESS <i>7601 SANDY SPR. RD. LAUREL, MD 20707</i>		25a. DATE OF REGISTRATION <i>FEB 24 1986</i>		REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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